

NEW HAMPSHIRE RETIREMENT SYSTEM

**EMPLOYER APPLICATION FOR RETIREE INSURANCE  
PREMIUM DEDUCTION REMITTANCE**

Employer Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Check made payable to: \_\_\_\_\_

Requested effective date: \_\_\_\_\_, 19\_\_\_\_\_  
(at least 60 days from current date)

**TABLE OF RATES**

COVERAGE	MONTHLY RATES-OLD	MONTHLY RATES-NEW
One Person	_____	_____
Two Person	_____	_____
Family	_____	_____
Medicomp I	_____	_____
Medicomp II	_____	_____
Medicomp III	_____	_____
*Other _____	_____	_____
*Other _____	_____	_____
*Other _____	_____	_____

\* Please assign a term or name to each "Other" category used.

**Mail to:** New Hampshire Retirement System  
4 Chenell Drive  
Concord, NH 03301-8509  
Attn: ANNUITY DIVISION

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